

## ► State Of Michigan Medicaid





# What is Medicaid?

Medicaid is a health insurance program that helps certain individuals and families with low incomes and resources to pay for some or all of their medical bills. It is the largest government program providing medical and health-related services in America. Medicaid is a jointly funded cooperative venture between the State and Federal governments. Within broad national guidelines that the Federal government provides, each state:

- establishes its own eligibility standards;
- determines the type, amount, duration, and scope of services;
- sets the rate of payment for services; and
- administers its own program.

Thus, Medicaid varies considerably from state to state.

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# The National Picture

- States and US Territories spend \$280 billion annually on Medicaid, of which \$160 billion is federal funds.
- Medicaid insures over 41 million individuals – Medicare insures only 40 million.
- 6 million people on Medicaid have Medicare as well.
- Medicaid pays for 1.3 million births a year or 37% of all births nationally.
- Medicaid finances the care of 2/3 of all nursing home residents.
- Medicaid pays for 17% of all hospital care and prescription drugs.

# Michigan Medicaid

The Medical Services Administration (MSA) within the Michigan Department of Community Health (MDCH) is responsible for the Medicaid Program in Michigan. Medicaid is the largest single item in the State's budget.

- Approximately 25% of Michigan's general fund revenue is appropriated for Medicaid.
- 1 of every 8 Michigan residents is eligible for Medicaid.
- Over 1/3 of all births in Michigan are financed by Medicaid.
- Seventy percent of nursing home expenditures in Michigan are financed by Medicaid.
- Over \$7.1 billion was appropriated for Medicaid services in fiscal year 2003-2004.
- Medicaid funding increased 40.2% since fiscal year 1999-2000.
- Medicaid caseload growth increased 27.4% (290,000 cases) since fiscal year 1999-2000.



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# Who is eligible for Medicaid in Michigan?

In January 2004, there were 1,351,108 people enrolled in Michigan Medicaid. (See *Michigan Medicaid Eligibles (by age) chart*)

- 810,665 age 0 – 19
- 432,355 age 20 – 64
- 108,088 age 65 and older

Michigan Medicaid covers both the categorically needy and the medically needy within certain income and asset limits. Income limits are based on a percentage of the federal poverty guidelines (commonly referred to as the federal poverty level or FPL). Eligibility for Medicaid is determined by local county Family Independence Agency (FIA) staff. (See *Michigan Medicaid Eligibles (by category) chart*)

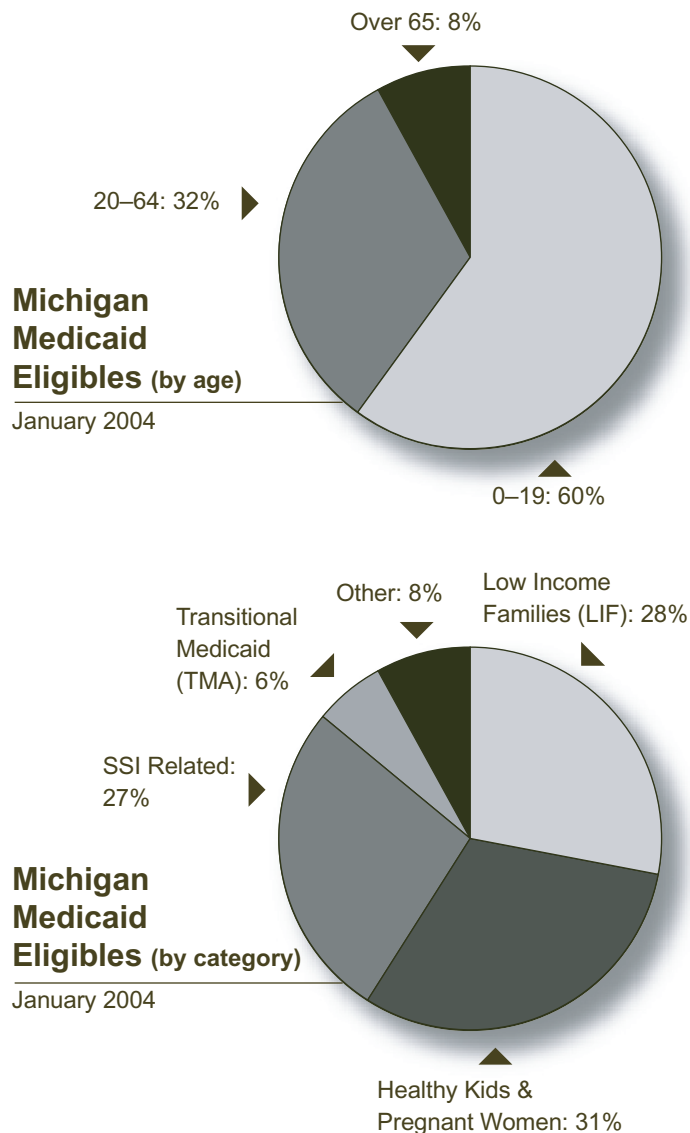
**Low Income Families (LIF)** with children may have income up to about 40% of the FPL. In 2004, this would be about \$530 a month for a family of 4.

**Healthy Kids (under age 21) and Pregnant Women** may have income up to 185% of the FPL depending on the age of the child. In 2004, this would be about \$1,925 maximum per month for a mother and one child

**Supplemental Security Income (SSI) Beneficiaries** include individuals who receive SSI and other aged, blind and disabled persons. This group includes aged adults, and blind and/or disabled children and adults. SSI recipients are automatically eligible for Medicaid. The Social Security Administration sets the amount of SSI income, which is about \$564 a month. Others in this group who do not qualify for SSI, may have income up to 100% of FPL. In 2004, this would be about \$775 a month for one person. Some individuals in this group may have to meet additional criteria to be eligible for Medicaid.

**Transitional Medical Assistance (TMA)** is available to families that have received Medicaid under LIF in at least 3 of the last 6 months. The family is no longer eligible under LIF because a parent has too much income due to employment. TMA is available automatically for 12 months.

The **Other** category includes, but is not limited to, caretaker relatives, refugees, certain persons under age 21, and participants in the Breast & Cervical Cancer Prevention and Treatment Program. There are varying income and asset tests for eligibility.



# What does Medicaid cover?

The federal government allows states considerable flexibility in determining the amount, duration and scope of covered health services. However, if a state receives federal matching funds (and they all do) then a state must cover specified basic services for physical and mental health that include:

- Inpatient and outpatient hospital services
- Prenatal care
- Vaccines for children
- Physicians' services and medical and surgical services furnished by a dentist
- Family planning services and supplies
- Laboratory and x-ray services
- Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) services
- Pediatric and family nurse practitioner services
- Nurse midwife services
- Medical transportation
- Health screening, diagnosis and treatment for children under age 21 (EPSDT)
- Home health care for persons eligible for skilled nursing services
- Nursing facility services for persons aged 21 and older

States may also receive federal matching funds to provide certain optional services. Michigan Medicaid covers most of the optional services that include:

- Diagnostic services
- Clinic services furnished by or under the direction of a physician
- Prescribed drugs, medical supplies, prosthetics and durable medical equipment
- Hearing, speech and vision services including eyeglasses and hearing aids (hearing aid coverage for adults was eliminated effective 10-1-03)
- Rehabilitation and physical therapy services
- Hospice care
- Case management services
- Respiratory care services
- Personal care services for people not in a hospital, nursing facility or institution
- Intermediate care facilities for the mentally retarded (ICFs/MR)
- Home and community based care for certain persons with chronic impairments
- Dental, podiatric and chiropractic services (eliminated for adults effective 10-1-03)
- Nursing facility services for children under age 21
- Private duty nursing services
- Substance abuse services
- PACE (program of all-inclusive care for the elderly) as an alternative to a nursing facility

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# How are services provided?

In Michigan, most people on Medicaid are enrolled in a managed health care plan (HMO) that is responsible for providing a full continuum of physical health services through network providers. Those not in a Medicaid health plan are in the fee-for-service program and can seek care from any provider willing to treat them. People who are in nursing homes or in community based care programs as an alternative to a nursing home, and people eligible for both Medicare and Medicaid cannot be enrolled in a Medicaid health plan. Over 70% of all Medicaid beneficiaries are mandated to be enrolled in a Medicaid health plan.

- In January 2004, 91.3% of Michigan Medicaid beneficiaries eligible to be in a health plan were enrolled in one. (834,515)
- As of December 31, 2002, over 57% of all Medicaid beneficiaries nationally were enrolled in a managed health care plan.

As of January 2004, there were 17 Medicaid health plans that service 78 counties within Michigan — only 5 counties were without a health plan option. Two or more health plan options are available to Medicaid beneficiaries in 69 of Michigan's 83 counties. This is an improvement over one year ago when there were 7 counties without a health plan and only 61 counties with two or more plans available.

Mental health, substance abuse and developmental disability specialty services and supports are provided under a managed behavioral health program pursuant to special waivers approved by the federal government. Medicaid beneficiaries receive these services under the authority and responsibility of Community Mental Health Services Programs (CMHSP) called Prepaid Inpatient Health Plans (PIHP). This is a public, statewide delivery system for behavioral health services. There are currently 18 PIHPs authorized to manage Medicaid specialty services and supports. Approximately 100,000 Medicaid beneficiaries were served in 2003.

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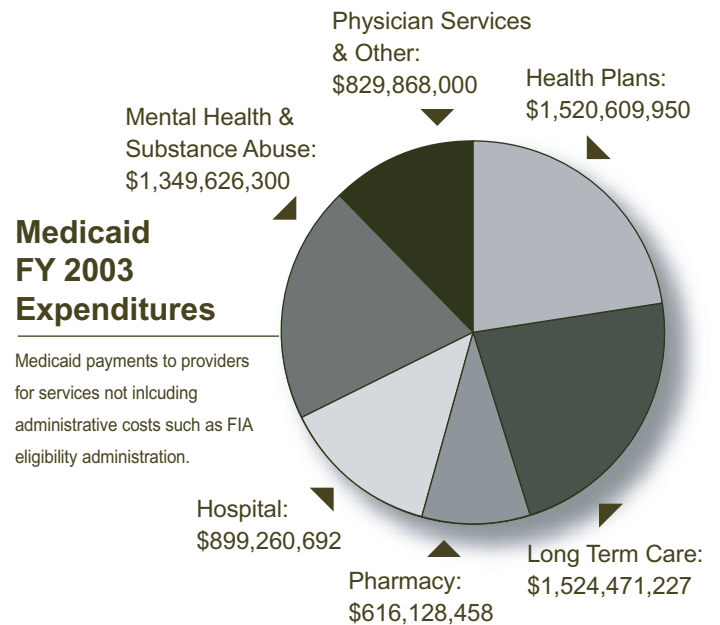
# How much does Michigan spend on Medicaid?

Medicaid is a joint federal and state funding effort. The federal government matches the funds the state spends on Medicaid according to the state's FMAP (federal medical assistance percentage). Michigan's FMAP is 58.84% until 6-30-04 and then it reverts to 55.89% for the remainder of the fiscal year (9-30-04). This means that for every \$1 spent on Medicaid services in Michigan, the federal government pays \$0.5884 and Michigan pays \$0.4116.

The following chart breaks out the major areas of expenditure for the Medicaid program. The "Physician Services and Other" in the chart includes the fee-for-service expenditures for all other covered care such as physician and other licensed practitioner services, ambulance services and other medical transportation, home health care, medical supplies and durable medical equipment, lab and x-ray, etc. The Mental Health and Substance Abuse portion includes mandatory and optional Medicaid services provided under the managed behavioral health program. (See *Medicaid FY 2003 Expenditures chart*)

The total expenditures for Michigan Medicaid for fiscal year (FY) 2003 were \$6,739,964,627. The state's share of this amount represents approximately 25% of Michigan's general fund revenue for FY 2003. FY 2003 includes October 1, 2002 through September 30, 2003.

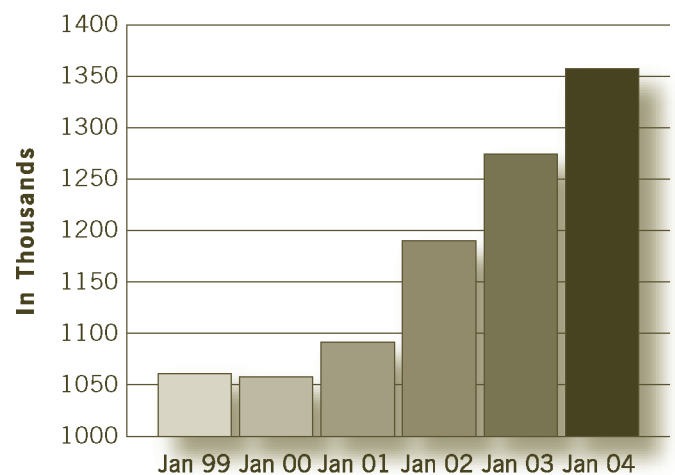
It is important to note that the vast majority of total Medicaid costs are related to serving the elderly and disabled population groups who have greater health care needs than other Medicaid beneficiaries. Aged, blind and disabled persons represent approximately 27% of the Medicaid population, but they account for about 70% of all Medicaid expenditures.



## Medicaid Caseload Growth

Medicaid has experienced a 27.4% growth in the number of people enrolled in Medicaid since FY 1999. In January 1999, there were 1,060,636 people enrolled in Michigan Medicaid. In January 2004, there were 1,351,108 people enrolled. That is an increase of more than 290,000 cases in five years. (See *Michigan Medicaid Caseload (1999-2004) chart*)

## Michigan Medicaid Caseload (1999-2004)





# Other health programs administered by the MSA

MSA administers other health programs that are not financed by Medicaid. Some of these programs are:

- **MIChild**

This is a health program for low income uninsured children of Michigan's working families. There is only an income test. A \$5 per month premium per family is charged regardless of the number of children insured. Contact 1-888-988-6300 for more information.

- **Maternity Outpatient Medical Services (MOMS)**

MOMS provides immediate outpatient prenatal care coverage to non-citizens who are eligible for emergency services only, and to teens and other pregnant women while a Medicaid application is pending. Local health departments help women apply for MOMS.

- **Adult Benefit Waiver (ABW)**

The ABW provides health care benefits for the State's childless adult residents with income at or below 35% of the FPL. This is about \$271 a month for a single adult. The ABW replaced the State Medical Assistance Program in January 2004.

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- **Children's Special Health Care Services (CSHCS)**

CSHCS is administered by the Public Health Administration. The MSA performs all the claim processing and remittance advice functions for CSHCS services. CSHCS was created to find, diagnose, and treat children in Michigan who have chronic illnesses or disabling conditions. Children must be under 21 years old and have a qualifying medical condition that is handicapping in nature and requires care by a medical or surgical sub specialist. Persons 21 and older with cystic fibrosis or certain coagulating blood disorders may also qualify for services. CSHCS promotes the development of service structures that offer specialty health care for the CSHCS qualifying condition that is family centered, community based, coordinated, and culturally competent. A CHSCS eligible person may also be dually eligible for Medicaid or for other programs administered by the MSA.

# Successes and Accomplishments of MSA for FY 2003

The MSA has experienced a reduced workforce since 2002, yet in 2003 the remaining staff has continued to run a very effective and efficient program. MSA administers their own third party liability recovery program and claim processing functions. The administrative rate is still less than 1% of all program expenditures. The Medicaid program itself is under intense pressure for cost containment in the light of the state's budget. Regardless, MSA staff has continued to meet the challenges and achieve success with notable accomplishments. Some of these include:

- **HIPAA (Health Insurance Portability and Accountability Act) Compliance with Transactions and Code Sets**

The MSA was ready for providers to submit electronic health care claims in the federally mandated standard format by the October 16, 2003 deadline.

- **HIPAA Compliance with the Privacy Law**

Privacy notices have been mailed to more than 1.4 million people who receive health benefits from the MDCH and all department staff has been trained. The majority of all requirements of the Privacy Law have been fulfilled.

- **New Provider Policy Manuals**

All Medicaid policy manuals were updated and consolidated into one electronic manual available on the MDCH website. In addition, the new manual was distributed on CD ROM to 20,700 providers.

- **The mihealth card**

Implemented in January 2003, the mihealth card is a permanent plastic health identification card that's issued to Michigan Medicaid, Emergency Medicaid, Children's Special Health Care Services and Adult Benefits Waiver beneficiaries. It fully replaced the monthly Medicaid blue paper card in April 2003, providing a savings to the state in monthly mailing costs.



MSA implemented a Pharmacy Preferred Drug List (PDL) for pharmacy drugs amidst tremendous political pressure from drug companies and patient advocates. The PDL is estimated to save the state \$42 million a year.

- **Quality Assurance Assessment Program and Provider Taxes**

In 2003, laws were passed to implement broad-based provider taxes for hospitals, nursing homes, and health plans. The purpose of the tax is to provide additional funding to Medicaid providers.

- **Pharmacy Preferred Drug List (PDL)**

MSA implemented a PDL for pharmacy drugs amidst tremendous political pressure from drug companies and patient advocates. The PDL is estimated to save the state \$42 million a year. All people covered under a pharmacy benefit in Michigan are currently limited in their choice of products that the health plan will cover. The PDL brings drug coverage for Medicaid beneficiaries more in line with coverage for the commercially insured population. Overall, the Medicaid coverage is still more expansive, but the PDL provides some control over the rapidly escalating costs.

- **Waiver Approvals**

MSA successfully obtained CMS (Center for Medicare and Medicaid Services) approval to continue operating several waiver programs that improve quality of care and save the state money. CMS approved the Comprehensive Health Plan Waiver and the Home and Community Based Waiver. Both provide a managed care approach to providing service to Medicaid recipients and must operate at a savings compared to regular fee-for-service Medicaid. Not only do these programs save money, they ensure quality coordinated care for beneficiaries.

- **Favorable Lewin Group Ranking in Pharmacy Study**

Michigan ranked second of all State Medicaid programs in a comparison of pharmacy spending in each state for aged, blind, disabled beneficiaries in Federal Fiscal Year 2002. Michigan policies contained pharmacy per member per month costs for this population better than 47 other states. The study, "Analysis of Pharmacy Carve-Out Option for the Arizona Health Care Cost Containment System" funded by the Center for Health Care Strategies, Inc., was released by the Lewin Group in January 2004.

## For more information Contact:

Michigan Department of Community Health  
[www.michigan.gov/mdch](http://www.michigan.gov/mdch)

email: [ProviderSupport@michigan.gov](mailto:ProviderSupport@michigan.gov)

Provider Inquiry Line – Providers Only  
1-800-292-2550

Beneficiary Helpline – Beneficiaries Only  
1-800-642-3195

Provider Inquiry  
P. O. Box 30731  
Lansing, Michigan 48909-8231

